Hospital Discharge Data Information Form
Report to the Arizona Department of Health Services

Facility Name: _____

Reporting Period: _____ Deadline Date: _____

Discharge Data File Reporting Names (use Standard Naming Convention outlined below):

Hospital Inpatient **(file type IP)**: _____

Hospital Emergency Department **(file type ED)**: _____

Standard Naming Convention: [facility ID]_[file type]_[reporting period]

EXAMPLE: MED1234_IP_2008-01

-MED1234 is the provider facility's state issued facility ID number.
-IP is the file type code for a hospital inpatient data submission file.
-2008-01 is the first half of 2008, January through June reporting period.

1) Provider Facility's Arizona State Issued Facility ID Number: _____

2) Provider Contact Person's Name: _____

3) Contact Person's Address: _____

4) Contact Person's Phone Number: _____

5) Contact Person's E-mail Address: _____

If the organization responsible for submitting the Discharge Data Reports is ***different*** from the Provider Organization, ALSO provide the following:

6) Data Submission Organization Name: _____

7) Contact Person's Name: _____

8) Contact Person's Address:_____

9) Contact Person's Phone Number: _____

10) Contact Person's E-mail Address: _____

Fax, Email or Mail this form to:

Arizona Department of Health Services
Discharge Data Review
150 N. 18th Ave., Suite 550
Phoenix, AZ 85007-3248

FAX: 602-542-2940
email: courtnd@azdhs.gov

http://www.azdhs.gov/plan/crr/index.htm.